X. Perinatal Care

In 1984 the Governor's Commission for Children and Youth established a Task Force on Infant Mortality. The efforts and leadership of this Task Force contribute positively to Mississippi's decrease in neonatal and postneonatal mortality rates. Strategies included developing and implementing a regionalization plan that addresses manpower scarcity and distribution problems, improving access to appropriate levels of care, and raising statewide awareness of the infant mortality problem. The Mississippi State Legislature extended the Task Force's statutory authority through July 1, 2005. Duties of the Task Force include:

(a) serve an advocacy and public awareness role with the general public regarding maternal and infant health issues;

(b) conduct studies on maternal and infant health and related issues;

(c) recommend to the Governor and the Legislature appropriate policies to reduce Mississippi's infant mortality and morbidity rates and to improve the status of maternal and infant health; and

(d) report annually to the Governor and the Legislature regarding the progress made toward the goals outlined in this Act and the actions taken with regard to recommendations previously made.

Amendments passed in 1997 direct the Task Force, in conjunction with the State Departments of Health, Human Services, Education, and the Division of Medicaid, to develop and implement a campaign for intensive outreach to encourage high risk populations to use family planning, prenatal care, and infant health services. The amendments also authorize the Task Force to apply for and expend grants or other contributions to promote maternal and infant health in Mississippi.

Although Mississippi's infant mortality rate has decreased to 10.4 in 2001, it is still one of the highest in the nation. In 2001, the number of infant deaths decreased by 25, and the number of live births to Mississippi residents decreased by 1,798.

Table X-1 presents Mississippi's infant mortality rates from 1991 to 2001, along with the rates for Region IV and for the United States. The non-white infant mortality rate of 14.6 represents a decrease from the 2000 rate of 15.1. The white infant mortality rate has remained 6.7 since 1999. Map X-1 shows the five-year average infant mortality rate by county for 1997-2001. Chapter III provides additional information on infant mortality by cause, by county, and by race.

Many factors contribute to Mississippi's high infant mortality rate: the high incidence of teenage pregnancy, low birthweight, low levels of acquired education, low socioeconomic status, lack of access for planned delivery services, and lack of acute medical care. The state is also experiencing a growing non-English speaking, uninsured population which adds to an increase of uncompensated care and delivery. High malpractice insurance rates and the threat of litigation continue to force physicians out of the practice of delivering babies, increasing problems of access to appropriate levels of perinatal care. Mississippi had 298 obstetricians, 26 certified nurse midwives, and 18 OB-GYN nurse practitioners serving in obstetrical practices during 2002.

The most notable advances made during the past decade include:

- Medicaid enhancements, including extended hospital days and increased physician reimbursement;
- access to new antepartum and newborn technology;
- outreach education for perinatal professionals; and
- implementation of the Children's Health Insurance Program (CHIP).

Concerted efforts through public and private providers of family planning, prenatal, neonatal, and infant care have contributed to the overall decline in infant mortality. The state must continue to provide the current basic health services and should attempt to improve access to prenatal care, delivery, and infant care; expand Medicaid services to children with special health care needs; expand perinatal regionalization; implement infant mortality/morbidity reviews; and reduce future unintended pregnancies.

Births to Mississippi teenagers decreased from 8,266 in 2000 to 7,536 in 2001 — 17.8 percent of the state's 42,277 total live births. Teen pregnancy is one of the major reasons for school drop-out. Teenage mothers are (a) more likely to be unmarried; (b) less likely to get prenatal care before the second trimester; (c) at higher risk of having low birthweight babies; (d) more likely to receive public assistance; (e) at greater risk for abuse or neglect; and (f) more likely to have children who will themselves become teen parents. Table X-2 presents the top ten counties in 1999, 2000, and 2001 with the highest percentage of total live births to teenagers.

Table X-1
Infant Mortality Rates
Mississippi, Region IV and USA All Races
1991 — 2001

Year	Mississippi	Region IV	USA
2001	10.4	N/A	N/A
2000	10.5	8.3	6.9
1999	10.2	8.4	7.1
1998	10.2	8.5	7.2
1997	10.6	12.1	10.6
1996	11.0	8.7	7.3
1995	10.5	8.9	7.6
1994	10.9	9.2	8.0
1993	11.4	9.7	8.4
1992	11.9	9.7	8.5
1991	11.4	10.2	8.9

N/A - Not Available

Source: Bureau of Public Health Statistics, Mississippi State Department of Health, 2001 RNOMU-Region IV Network for Utilization Data Management and Utilization - September, 2002

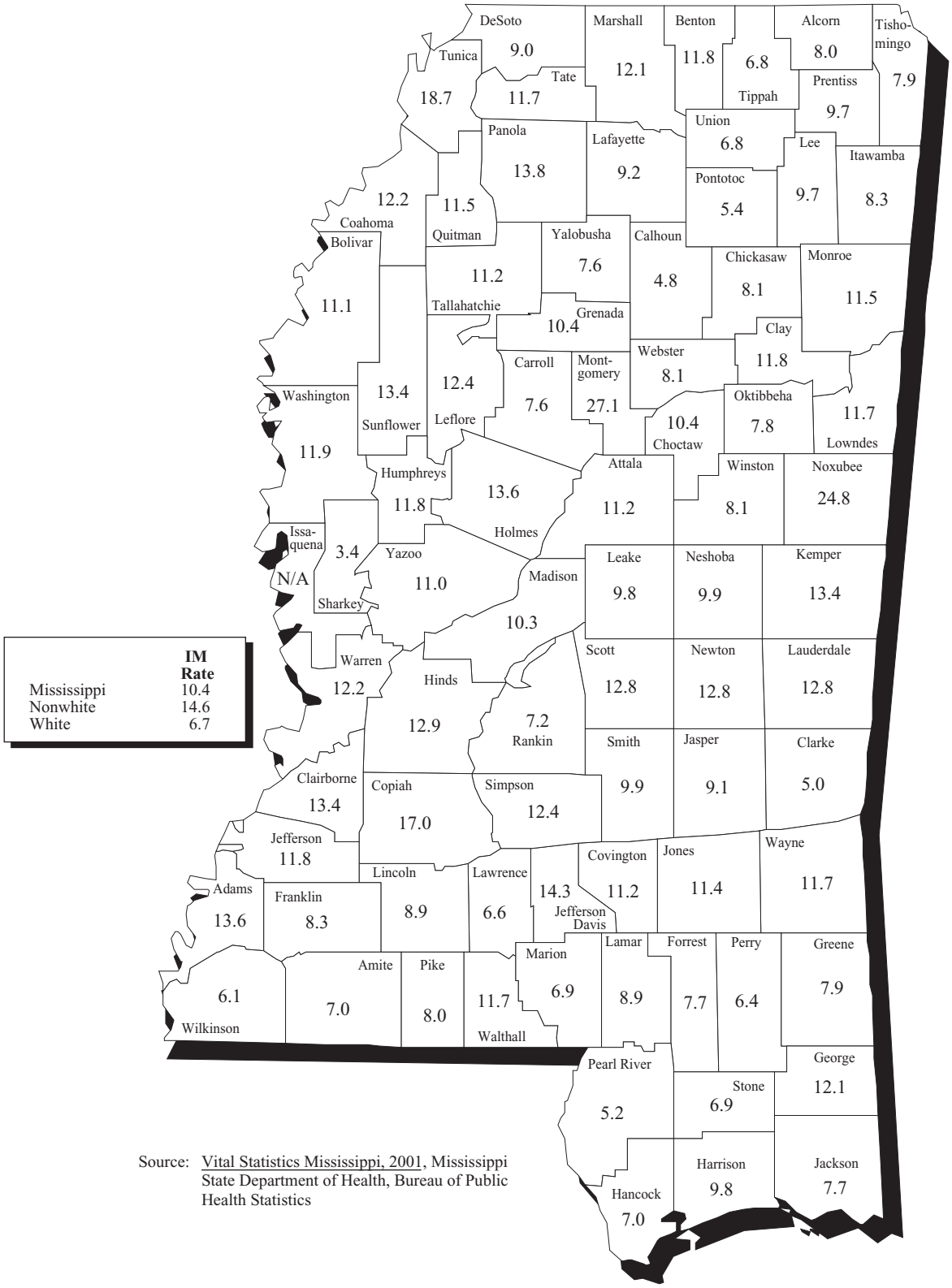
Table X-2
Top Ten Counties with the Highest Percentage of Total Live Births to Teenagers
2001, 2000,1999

County	2001	County	2000	County	1999
Humpheys	33.8	Coahoma	31.0	Issaquena	35.0
Quitman	31.6	Tallahatchie	30.0	Humphreys	32.0
Tunica	30.8	Sunflower	29.1	Coahoma	31.1
Tallahatchie	30.3	Franklin	26.4	Quitman	30.8
Coahoma	30.2	Humphreys	26.4	Bolivar	29.3
Sunflower	28.2	Bolivar	25.8	Sharkey	29.2
Wilkinson	26.1	Holmes	25.3	Tallahatchie	29.0
Jefferson	25.4	Covington	25.2	Tunica	28.4
Benton	25.2	Leflore	25.2	Simpson	27.8
Holmes	25.1	Jefferson	25.0	Washington	27.4
Mississippi	**17.8**	**Mississippi**	**18.8**	**Mississippi**	**24.97**

Source: Vital Statistics Mississippi, 1999, 2000, 2001, Mississippi State Department of Health, Bureau of Public Health Statistics

Map X-1

Infant Mortality Rates by County or Residence 1997 to 2001 (Five-Year Average)



Source: Vital Statistics Mississippi, 2001, Mississippi State Department of Health, Bureau of Public Health Statistics

Mississippi State Department of Health

The Mississippi State Department of Health provided maternity services statewide to more than 11,836 pregnant women whose incomes were at or below 185 percent of the federal poverty level in FY 2002. The MSDH uses the Hollister Maternity Record, with risk status updated at each visit and referral to obstetricians and appropriate hospitals as indicated. A multidisciplinary team at the county health department, including physicians, nurse practitioners, nurses, nutritionists, and social workers, provides ambulatory care throughout pregnancy and the postpartum period. Following birth, the team emphasizes family planning services for the mother and well-child care for the infant and places a high priority on close follow-up for 12 months after delivery. The Supplemental Food Program for Women, Infants, and Children (WIC) provides essential nutritional counseling and supplemental foods to pregnant and breastfeeding women, as well as infants and children.

Each county health department offers family planning services targeted toward sexually active teens and women 20-44 years of age with incomes below 150 percent of the poverty level. More than 100,000 Mississippians, some 32,376 of them 19 years of age or younger, took advantage of comprehensive family planning services during FY 2002. Federal support had steadily decreased since the 1980s; however, it has recently begun to increase slightly. The family planning program receives very few state dollars.

Inappropriate pregnancies often have a detrimental impact on individuals, families, and society. No practical means exists to accumulate data that would measure the incidence of unintended pregnancy. However, when compared to the nation, Mississippi's high fertility rate (66.6), high birth rate (14.9), high percent of births to teens (17.8), high percent of unwed parents (46.3), and high percent of mothers without a high school education (24.9) would lead to the assumption that the state has a high rate of unintentional pregnancies. Based on the number and characteristics of program participants, health officials estimate that the Family Planning Program helped prevent approximately 16,808 unintended pregnancies in FY 2002, including approximately 5,277 pregnancies to teenagers. The State Department of Education reported 98 pregnancy related dropouts statewide during the 2001-2002 school term. This number reflected a 32.4 percent decrease in pregnancy related dropouts from the 2000-2001 school year.

The MSDH is involved in several special maternity/perinatal service initiatives:

Perinatal Regionalization: MSDH conduced a study of perinatal regionalization among very low birthweight infants born instate and in-hospital to Mississippi residents from 1997-1999. The purposes of the study were to: (1) determine the population of these infants that were born in each level hospital; and (2) assess the effects of hospital level on neonate mortality while controlling for maternal risk factors. Hospitals were categorized as level A to level D, with level A hospitals having the highest level or perinatal services. The findings were:

- Forty percent of very low birthweight infants, born of Mississippi residents who delivered instate, were born in a level A hospital;
- As hospitals levels decrease, mortality significantly increased even when controlled for less than 1,000 gram infants (exception: large volume, level B hospitals);
- Among infants less than 1,000 grams, mortality incrementally increased as the hospital level decreased.

These findings were presented in January 2003 to the original steering committee associated with this study and to the Mississippi Perinatal Association during March 2003. The MSDH is developing a plan to address perinatal regionalization issues.

The ***Perinatal High Risk Management/Infant Services System (PHRM/ISS)*** is a multi-disciplinary, family oriented, risk reduction program administered statewide by the Mississippi State Department of Health for high risk pregnant and postpartum women and infants. The program is designed to reduce low birthweight and infant mortality by providing a comprehensive array of enhanced services such as nutrition and psychosocial assessments, counseling, home visiting, transportation assistance, and health education. Case management is provided to high risk clients by nurses, nutritionists, and social workers. In FY 2002, the program served 38,940 high-risk mothers, infants, and post-partum women.

The Mississippi Infant Mortality Task Force assisted the MSDH in obtaining a Special Project of Regional and National Significance (SPRANS) grant from the Bureau of Material and Child Health to conduct a three-year Fetal and Infant Mortality Review (FIMR) study. The project operated in five counties in Public Health District I and three counties in District III. The MSDH plans to incorporate the FIMR project into the statewide Material and Infant Mortality Surveillance program. In this surveillance system, information is collected to analyze factors associated with the death of a pregnant woman or a woman who has recently experienced the death of an infant. This information leads to improved services, resources, and community support for pregnant women, infants, and their families.

Pregnancy Risk Assessment Monitoring System (PRAMS)

The MSDH has received funding to implement a statewide PRAMS project. PRAMS is part of a Centers for Disease Control and Prevention (CDC) initiative to reduce infant mortality and low birthweight. PRAMS is an ongoing, state-specific, population-based surveillance system designed to identify and monitor selected behavior and experiences before, during, and after pregnancy. The overall goal of PRAMS is to reduce infant morbidity and mortality by influencing maternal behavior during and immediately after pregnancy.

Four specific objectives to achieve PRAMS' goals are to:

- Collect maternity-related population-based data;
- Conduct comprehensive data analysis to better understand the relationship between behavior, attitudes, and experiences during and immediately after pregnancy;
- Translate results from analyses into information for planning and evaluating public health programs and policy; and
- Build the capacity of states to collect, analyze, and translate data to address relevant public health services.

Perinatal Legislation

In 1966, the Mississippi Legislature expanded Medicaid eligibility, increased physician fees for obstetrical deliveries, and increased the number of reimbursable hospital inpatient days for children. That same year, legislation was passed that requires an official to certify the death of any female between the ages of 10 and 50 and to indicate on the death certificate whether the decedent (a) was pregnant at the time of death; (b) had given birth within the preceding 90 days; or (c) had a miscarriage within the preceding 90 days.

The 1998 Legislature passed the Mississippi Children's Health Act which contained provisions for a new insurance program called CHIP (Children's Health Insurance Program). The CHIP will insure children under the age of 19 whose families have incomes below the federal poverty level. The responsibility of determining eligibility for CHIP, as well as Medicaid, falls to the Mississippi Department of Human Services. In 2001, the Legislature removed the waiting period for eligibility.

The 2001 Legislature extended the authority of the Infant Mortality Task Force through July 1, 2005. The Task Force addresses infant mortality issues by recommending needed new legislation and encouraging cooperation among agencies and organizations to achieve desirable objectives.

Many groups have provided support to improve perinatal services in Mississippi. These groups include the Mississippi Human Services Coalition, the Mississippi Hospital Association, the Mississippi Perinatal Association, the Southern Governor's Association, the Medical Access Task Force, the Mississippi Chapter of the American Academy of Pediatrics, the State Medical Association, the University Medical Center, and the Primary Health Care Association. In addition, Keesler Air Force Base is instrumental in treating high-risk mothers and infants requiring tertiary care.

Physical Facilities for Perinatal Care

Hospital-based perinatal care should meet the pathologic, physiologic, and psychosocial needs of the family unit, with defined areas for prenatal care, labor, delivery, recovery, newborn care, and postpartum care in a contiguous location. Table X-3 gives selected obstetrical data for 20 hospitals with the most deliveries in calendar year 2002. Only three hospitals reported more than 2,000 obstetrical deliveries, accounting for 22.5 percent of the state's total hospital deliveries. These three hospitals were the University of Mississippi Medical Center, with 3,538 deliveries; Forrest General Hospital, with 2,871 deliveries; and North Mississippi Medical Center, with 2,432 deliveries.

Seventeen hospitals had between 800 and 2,000 hospital deliveries, for 47.3 percent (18,552) of the total hospital deliveries. An additional 36 hospitals had fewer than 800 deliveries each, for a total of 11,812 (30.1 percent of the total hospital deliveries). Table X-4 presents all of the hospitals in the state reporting deliveries in calendar year 2002.

The number of hospitals reporting obstetrical services remains virtually the same since 1990, as shown in Figure X-1. Map X-2 depicts all Mississippi hospitals providing the various levels of obstetrical and newborn services. Perinatal facilities are maldistributed as to structure, equipment, and staffing, with the greatest deficiencies in the Delta region. The Task Force on Infant Mortality has recommended identifying and licensing OB services in hospitals using the levels of care designation.

In recent years Mississippi has experienced major changes in its health care systems. These changes have greatly impacted perinatal regionalization, moving the system from a statewide structure to multiple inter and intra state systems. Multiple overlapping regional systems have resulted. However, the University of Mississippi Medical Center in Jackson is still the state's only tertiary perinatal center (excluding the Keesler Air Force Base Medical Center). Several Mississippi health care systems refer patients to out of state facilities. This practice is not new, but is expanding.

The recruitment and retention of obstetricians has decreased slightly, with the number shrinking from 302 in 2002 to 298 in 2003. The number of hospitals with obstetrical services increased from 55 to 56 during the year.

Table X-3

Utilization Data for 20 Hospitals with the Highest Reported Number of Obstetrical Deliveries

Facility	County	Number of Deliveries	Number of Reported OB Beds	Occupancy Rate	Average Length of Stay (days)
University of Mississippi Medical Center	Hinds	3,538	62	70.3	3.5
Forrest General Hospital	Forrest	2,871	35	65.2	2.7
North Mississippi Medical Center	Lee	2,432	69	37.6	2.6
River Oaks Hospital	Rankin	1,887	10	142.1	2.6
Baptist Memorial Hospital - DeSoto	DeSoto	1,534	0	0.0	0.0
Central Mississippi Medical Center	Hinds	1,273	0	0.0	0.0
Woman's Hospital - River Oaks	Rankin	1,212	18	54.8	2.6
Memorial Hospital at Gulfport	Harrison	1,155	27	34.1	2.6
Jeff Anderson Regional Medical Center	Lauderdale	1,148	32	31.0	2.3
River Region Health System	Warren	1,082	28	35.3	3.1
Oktibbeha County Hospital	Oktibbeha	1,055	0	0.0	0.0
South Central Regional Medical Center	Jones	1,030	19	55.8	2.6
Mississippi Baptist Medical Center	Hinds	1,019	56	42.9	2.1
Rush Foundation Hospital	Lauderdale	960	20	38.8	3.0
Baptist Memorial Hospital - Golden Triangle	Lowndes	960	17	52.3	3.6
Northwest Mississippi Regional Medical Ctr.	Coahoma	929	0	0.0	0.0
Southwest Mississippi Regional Medical Ctr.	Pike	867	9	116.1	3.0
Singing River Hospital	Jackson	822	22	25.2	2.5
Baptist Memorial Hospital - Union County	Union	812	0	0.0	0.0
Baptist Memorial Hospital - North MS	Lafayette	807	0	0.0	0.0

Sources: Applications for Renewal of Hospital License for Calendar Year 2003 and Fiscal Year 2002 Annual Hospital Report

Table X-4
Number of Hospital Deliveries
Mississippi Hospitals
FY 2002

County	Facility	OB Beds Set Up	Number of Deliveries
Adams	Natchez Community Hospital	0	363
Adams	Natchez Regional Medical Center	6	554
Alcorn	Magnolia Regional Health Center	9	603
Attala	Montfort Jones Memorial Hospital	7	160
Bolivar	Bolivar Medical Center	20	514
Clay	Clay County Medical Center	0	410
Coahoma	Northwest Mississippi Regional Medical Center	0	929
Copiah	Hardy Wilson Memorial Hospital	6	68
Covington	Covington County Hospital	0	96
DeSoto	Baptist Memorial Hospital - DeSoto County	0	1,534
Forrest	Forrest General Hospital	35	2,871
George	George County Hospital	0	192
Grenada	Grenada Lake Medical Center	7	696
Hancock	Hancock Medical Center	0	407
Harrison	Memorial Hospital at Gulfport	27	1,155
Harrison	Biloxi Regional Medical Center	22	696
Harrison	Garden Park Community Hospital	9	487
Harrison	Gulf Coast Medical Center	4	299
Hinds	Central Mississippi Medical Center	0	1,273
Hinds	University Medical Center	62	3,538
Hinds	Mississippi Baptist Medical Center	56	1,019
Hinds	St. Dominics Hospital	0	285
Holmes	University Hospital & Clinics	4	54
Jackson	Ocean Springs Hospital	10	426
Jackson	Singing River Hospital	22	822
Jeff Davis	Prentiss Regional Hospital	0	2
Jones	South Central Regional Medical Center	19	1,030
Lafayette	Baptist Memorial Hospital - North Mississippi	0	807
Lamar	Wesley Medical Center	0	773
Lauderdale	Riley Memorial Hospital	10	403
Lauderdale	Rush Foundation Hospital	20	960
Lauderdale	Jeff Anderson Regional Medical Center	32	1,148
Lee	North Mississippi Medical Center	69	2,432
Leflore	Greenwood Leflore Hospital	16	518
Lincoln	King's Daughters Hospital - Brookhaven	7	545
Lowndes	Baptist Memorial Hospital - Golden Triangle	17	960
Madison	Madison County Medical Center	0	258
Monroe	Gilmore Memorial Hospital	15	659
Newton	Alliance Laird Hospital	0	1
Oktibbeha	Oktibbeha County Hospital	0	1,055
Panola	Tri-Lakes Medical Center	0	197
Pearl River	L. O. Crosby Memorial Hospital	14	336

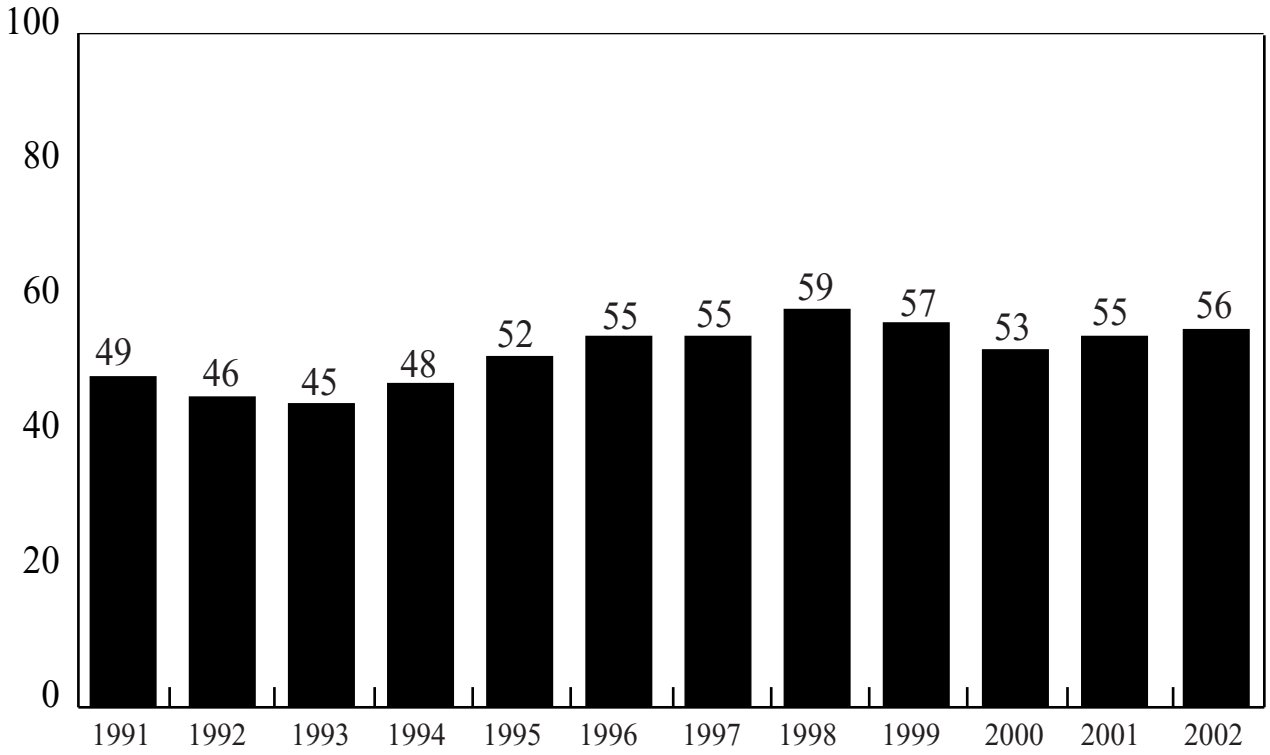
Table X-4 (Continued)
Number of Hospital Deliveries
Mississippi Hospitals
FY 2002

County	Facility	OB Beds Set Up	Number of Deliveries
Pike	Southwest Mississippi Regional Medical Center	9	867
Quitman	Quitman County Hospital	0	1
Rankin	Woman's Hospital at River Oaks	18	1,212
Rankin	River Oaks Hospital	10	1,887
Scott	Scott Regional Hospital	0	1
Simpson	Magee General Hospital	2	131
Sunflower	South Sunflower County Hospital	0	344
Tate	North Oak Regional Medical Center	0	2
Union	Baptist Memorial Hospital - Union County	0	812
Warren	River Region Health System	28	1,082
Washington	Delta Regional Medical Center	11	617
Washington	King's Daughters Hospital-Greenville	21	394
Wayne	Wayne General Hospital	7	251
Wilkinson	Field Memorial Community Hospital	0	69
Total		**631**	**39,205**

Source: Applications for Renewal of Hospital License for Calendar Year 2002 and FY 2001 Annual Hospital Report

Figure X-1

Mississippi Hospitals with Obstetrical and Newborn Services



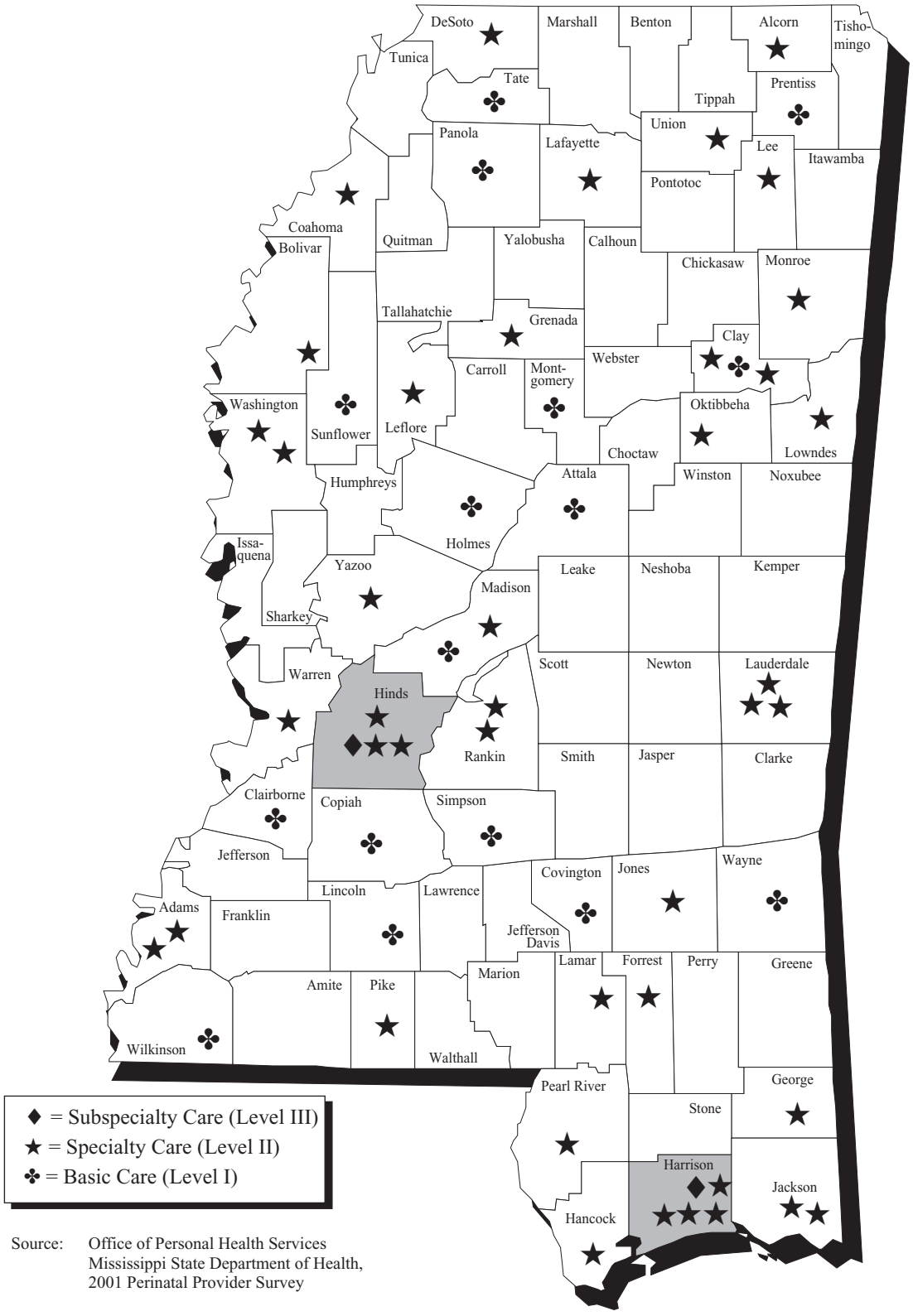
Level III - Teritiary Perinatal Center - 2*
Level II - Neonatalogy Supervised NICU - 11
Level II - Specialty - 29
Level I - Basic - 11
Birthing Center - 1

* University Medical Center and Keesler AFB

Source: Office of Personal Health Services
Mississippi State Department of Health 2002 Perinatal Provider Survey

Map X-2

Mississippi Hospitals With Obstetrical And Newborn Services - All Levels



Source: Office of Personal Health Services
Mississippi State Department of Health,
2001 Perinatal Provider Survey

Guidelines for the Operation of Perinatal Units
(Obstetrics and Newborn Nursery)

ORGANIZATION

Obstetrics and newborn nursery services shall be under the direction of a member of the staff of physicians who has been duly appointed for this service and who has experience in maternity and newborn care.

There shall be a qualified professional registered nurse responsible at all times for the nursing care of maternity patients and newborn infants.

Provisions shall be made for pre-employment and annual health examinations for all personnel on this service.

Physical facilities for perinatal care in hospitals shall be conducive to care that meets the normal physiologic and psychosocial needs of mothers, neonates and their families. The facilities provide for deviations from the norm consistent with professionally recognized standards/guidelines.

The obstetrical service should have facilities for the following components:

A. Antepartum care and testing.

B. Fetal diagnostic services.

C. Admission/observation/waiting.

D. Labor.

E. Delivery/cesarean birth.

F. Newborn nursery.

G. Newborn intensive care (Specialty and Subspecialty care only).

H. Recovery and postpartum care.

I. Visitation.

STAFFING

The facility is staffed to meet its patient care commitments consistent with professionally recognized guidelines. There must be a registered nurse immediately available for direct patient care.

LEVELS OF CARE

Basic Care

A. Surveillance and care of all patients admitted to the obstetric service, with an established triage system for identifying high-risk patients who should be transferred to a facility that provides specialty or sub-specialty care.

B. Proper detection and supportive care of unanticipated maternal-fetal problems that occur during labor and delivery.

C. Capability to begin an emergency cesarean delivery within 30 minutes of the decision to do so.

D. Availability of blood bank services on a 24-hour basis.

E. Availability of anesthesia, radiology, ultrasound, and laboratory services available on a 24-hour basis.

F. Care of postpartum conditions.

G. Evaluation of the condition of healthy neonates and continuing care of these neonates until their discharge.

H. Resuscitation and stabilization of all neonates born in hospital.

I. Stabilization of small or ill neonates before transfer to a specialty or sub-specialty facility.

J. Consultation and transfer agreement.

K. Nursery care.

L. Parent-sibling-neonate visitation.

M. Data collection and retrieval.

Specialty Care

A. Performance of basic care services as described above.

B. Care of of high-risk mothers and fetuses both admitted and transferred from other facilities.

C. Stabilization of ill newborns prior to transfer.

D. Care of preterm infants with a birth weight of 1,500 grams or more.

E. Treatment of moderately ill larger preterm and term newborns

Sub-specialty Care

A. Provision of comprehensive perinatal care services for both admitted and transferred mothers and neonates of all risk categories, including basic and specialty care services as described above.

B. Research and educational support.

C. Analysis, and evaluation of regional data, including those on complications.

D. Evaluation of new technologies and therapies.

E. Maternal and neonate transport.

PERINATAL CARE SERVICES

Antepartum Care

There should be policies for the care of pregnant patients with obstetric, medical, or surgical complications and for maternal transfer.

Intra-partum Services: Labor and Delivery

Intra-partum care should be both personalized and comprehensive for the mother and fetus. There should be written policies and procedures in regard to:

1. Assessment.

2. Admission.

3. Medical records (including complete prenatal history and physical).

4. Consent forms.

5. Management of labor including assessment of fetal well-being:

    a. Term patients.
    b. Preterm patients.
    c. Premature rupture of membranes.
    d. Preeclampsia/eclampsia.
    e. Third trimester hemorrhage.
    f. Pregnancy Induced Hypertension (PIH).

6. Patients receiving oxytocics or tocolytics.

7. Patients with stillbirths and miscarriages.

8. Pain control during labor and delivery.

11. Assessment of fetal maturity prior to repeat cesarean delivery or induction of labor.

12. Vaginal birth after cesarean delivery.

13. Assessment and care of neonate in the delivery room.

14. Infection control in the obstetric and newborn areas.

15. A delivery room record shall be kept that will indicate:

    a. The name of the patient.
    b. Date of delivery.
    c. Sex of infant.
    d. Apgar.
    e. Weight.
    f. Name of physician.
    g. Name of persons assisting.
    h. What complications, if any, occurred.
    i. Type of anesthesia used.
    j. Name of person administering anesthesia.

16. Maternal transfer.

17. Immediate postpartum/recovery care.

18. Housekeeping.

New Born Care

There shall be policies and procedures for providing care of the neonate including:

1. Immediate stabilization period.

2. Neonate identification and security.

3. Assessment of neonatal risks.

4. Cord blood, Coombs, and serology testing.

5. Eye care.

6. Subsequent care.

7. Administration of Vitamin K.

8. Neonatal screening.

9. Circumcision.

10. Parent education.

11. Visitation.

12. Admission of neonates born outside of facility.

13. Housekeeping.

14. Care of or stabilization and transfer of high-risk neonates.

Postpartum Care

There shall be policies and procedures for postpartum care of mother:

1. Assessment.

2. Subsequent care (bed rest, ambulation, diet, care of the vulva, care of the bowel and bladder functions, bathing, care of the breasts, temperature elevation).

3. Postpartum sterilization.

4. Immunization: RHIG and Rubella.

5. Discharge planning.

Source: *Guidelines for Perinatal Care, Second and Fourth Editions*, American Academy of Pediatrics and the American College of Obstetricians and Gynecologists, 1988, 1992, and 1997.

Certificate of Need
Criteria and Standards
for
Obstetrical Services

Should the Mississippi State Department of Health receive a Certificate of Need application regarding the acquisition and/or otherwise control of major medical equipment or the provision of a service for which specific CON criteria and standards have not been adopted, the application shall be deferred until the Department of Health has developed and adopted CON criteria and standards. If the Department has not developed CON criteria and standards within 180 days of receiving a CON application, the application will be reviewed using the general CON review criteria and standards presented in the *Mississippi Certificate of Need Review Manual* and all adopted rules, procedures, and plans of the Mississippi State Department of Health.

Policy Statement Regarding Certificate of Need Applications for the Offering of Obstetrical Services

1. An applicant is required to provide a reasonable amount of indigent/charity care as described in Chapter I of this *Plan*.

2. Perinatal Planning Areas (PPA): The MSDH shall determine the need for obstetrical services using the Perinatal Planning Areas as outlined on Map X-3 at the end of this chapter.

3. Optimum Utilization: For planning and CON purposes, optimum utilization is defined as 60 percent occupancy per annum for all existing OB beds in an OB unit.

4. Travel Time: Obstetrical services should be available within one (1) hour normal travel time of 95 percent of the population in rural areas and within 30 minutes normal travel time in urban areas.

5. Dedicated Beds: An applicant proposing to offer obstetrical services shall dedicate a minimum of six (6) beds.

6. Preference in CON Decisions: The MSDH shall give preference in CON decisions to applications that propose to improve existing services and to reduce costs through consolidation of two basic obstetrical services into a larger, more efficient service over the addition of new services or the expansion of single service providers.

7. Patient Education: Obstetrical service providers shall offer an array of family planning and related maternal and child health education programs that are readily accessible to current and prospective patients.

8. Levels of Care: Basic Perinatal Centers – provide basic inpatient care for pregnant women and newborns without complications.

   Specialty Perinatal Centers – provide management for certain high-risk pregnancies, including maternal referrals from basic care centers as well as basic perinatal services.

   Subspecialty Perinatal Centers – provide inpatient care for maternal and fetal complications as well as basic and specialty care.

9. An applicant proposing to offer obstetrical services shall be equipped to provide basic perinatal services in accordance with the guidelines contained in the *Minimum Standards of Operation for Mississippi Hospitals.*

10. An applicant proposing to offer obstetrical services shall agree to provide an amount of care to Medicaid mothers/babies comparable to the average percentage of Medicaid care offered by other providers of the requested service within the same, or most proximate geographic area.

Certificate of Need Criteria and Standards for Obstetrical Services

The Mississippi State Department of Health will review applications for a Certificate of Need to establish "new" obstetric services under the statutory requirements of Sections 41-7-173, 41-7-191, and 41-7-193, Mississippi Code of 1972, as amended. The MSDH will also review applications for Certificate of Need according to the general criteria listed in the *Mississippi Certificate of Need Review Manual*; all adopted rules, procedures, and plans of the Mississippi State Department of Health; and the specific criteria and standards listed below.

The establishment of obstetrical services or the expansion of the existing service shall require approval under the Certificate of Need statute if the $2,000,000 capital expenditure threshold is crossed.

Provision for individual units should be consistent with the regionalized perinatal care system involved. Those facilities desiring to provide obstetric services shall meet the Basic facility minimum standards as previously listed under *Guidelines for the Operation of Perinatal Units.*

1. **Need Criterion:**

   a. the application shall demonstrate how the applicant can reasonably expect to deliver a minimum of 150 babies the first full year of operation and 250 babies by the second full year; and

   b. the applicant shall demonstrate, subject to verification by the Mississippi State Department of Health, that all existing OB beds within the proposed Perinatal Planning Area have maintained an optimum utilization rate of 60 percent for the most recent 12-month reporting period.

2. Any facility offering obstetrical services shall have designated obstetrical beds.

3. The application shall document that the facility will provide one of the three types of perinatal services: Basic, Specialty, or Subspecialty.

4. The facility shall provide full-time nursing staff in the labor and delivery area on all shifts. Nursing personnel assigned to nursery areas in Basic Perinatal Centers shall be under the direct supervision of a qualified professional nurse.

5. Any facility proposing the offering of obstetrical services shall have written policies delineating responsibility for immediate newborn care, resuscitation, selection and maintenance of necessary equipment, and training of personnel in proper techniques.

6. The application shall document that the nurse, anesthesia, neonatal resuscitation, and obstetric personnel required for emergency cesarean delivery shall be in the hospital or readily available at all times.

7. The application shall document that the proposed services will be available within one (1) hour normal driving time of 95 percent of the population in rural areas and within 30 minutes normal driving time in urban areas.

8. The applicant shall affirm that the hospital will have protocols for the transfer of medical care of the neonate in both routine and emergency circumstances.

9. The application shall affirm that the applicant will record and maintain, at a minimum, the following information regarding charity care and care to the medically indigent and make it available to the Mississippi State Department of Health within 15 business days of request:

    a. source of patient referral;

    b. utilization data e.g., number of indigent admissions, number of charity admissions, and inpatient days of care;

    c. demographic/patient origin data;

    d. cost/charges data; and

    e. any other data pertaining directly or indirectly to the utilization of services by medically indigent or charity patients which the Department may request.

10. The applicant shall document that within the scope of its available services, neither the facility nor its participating staff shall have policies or procedures which would exclude patients because of race, age, sex, ethnicity, or ability to pay.

Certificate of Need
Criteria and Standards
for
Neonatal Special Care Services

Should the Mississippi State Department of Health receive a Certificate of Need application regarding the acquisition and/or otherwise control of major medical equipment or the provision of a service for which specific CON criteria and standards have not been adopted, the application shall be deferred until the Department of Health has developed and adopted CON criteria and standards. If the Department has not developed CON criteria and standards within 180 days of receiving a CON application, the application will be reviewed using the general CON review criteria and standards presented in the *Mississippi Certificate of Need Review Manual* and all adopted rules, procedures, and plans of the Mississippi State Department of Health.

Policy Statement Regarding Certificate of Need Applications for the Offering of Neonatal Special Care Services

1. An applicant is required to provide a reasonable amount of indigent/charity care as described in Chapter I of this *Plan*.

2. Perinatal Planning Areas (PPA): The MSDH shall determine the need for obstetrical services using the Perinatal Planning Areas as outlined on Map X-3 at the end of this chapter.

3. Bed Limit: The total number of neonatal special care beds should not exceed four (4) per 1,000 live births in a specified PPA as defined below:

   a. one (1) intensive care bed per 1,000 live births; and

   b. three (3) intermediate care beds per 1,000 live births.

4. Size of Facility: A single neonatal special care unit (Specialty or Subspecialty) should contain a minimum of 15 beds.

5. Optimum Utilization: For planning and CON purposes, optimum utilization is defined as 75 percent occupancy per annum for all existing providers of neonatal special care services within an applicant's proposed Perinatal Planning Area.

6. Levels of Care: Basic – Units provide uncomplicated care.

   Specialty – Units provide basic, intermediate, and recovery care as well as specialized services.

   Subspecialty – Units are staffed and equipped for the most intensive care of newborns as well as intermediate and recovery care.

7. An applicant proposing to offer neonatal special care services shall agree to provide an amount of care to Medicaid babies comparable to the average percentage of Medicaid care offered by the other providers of the requested services.

Certificate of Need Criteria and Standards for Neonatal Special Care Services

The Mississippi State Department of Health will review applications for a Certificate of Need to establish neonatal special care services under the statutory requirements of Sections 41-7-173, 41-7-191, and 41-7-193, Mississippi Code of 1972, as amended. The MSDH will also review applications for Certificate of Need according to the general criteria listed in the *Mississippi Certificate of Need Review Manual*; all adopted rules, procedures, and plans of the Mississippi State Department of Health; and the specific criteria and standards listed below.

Neonatal special care services are reviewable under Certificate of Need when either the establishment or expansion of the services involve a capital expenditure in excess of $2,000,000.

Those facilities desiring to provide neonatal special care services shall meet the minimum standards for the specified facility (Specialty or Subspecialty) as previously listed under *Minimum Standards of Care for Neonatal Special Care Services*.

1. **Need Criterion: The application shall demonstrate that the Perinatal Planning Area (PPA) wherein the proposed services are to be offered had a minimum of 3,600 deliveries for the most recent 12-month reporting period and that each existing provider of neonatal special care services within the proposed PPA maintained an optimum utilization rate of 75 percent for the most recent 12-month period. The MSDH shall determine the need for neonatal special care services based upon the following:**

   a. one (1) neonatal intensive care bed per 1,000 live births in a specified Perinatal Planning Area for the most recent 12-month reporting period; and

   b. three (3) neonatal intermediate care beds per 1,000 live births in a specified Perinatal Planning Area for the most recent 12-month reporting period.

2. A single neonatal special care unit (Specialty or Subspecialty) should contain a minimum of 15 beds (neonatal intensive care and/or neonatal intermediate care). An adjustment downward may be considered for a specialty unit when travel time to an alternate unit is a serious hardship due to geographic remoteness.

3. The application shall document that the proposed services will be available within one (1) hour normal driving time of 95 percent of the population in rural areas and within 30 minutes normal driving time in urban areas.

4. The application shall document that the applicant has established referral networks to transfer infants requiring more sophisticated care than is available in less specialized facilities.

5. The application shall affirm that the applicant will record and maintain, at a minimum, the following information regarding charity care and care to the medically indigent and make it available to the Mississippi State Department of Health within 15 business days of request:

   a. source of patient referral;

   b. utilization data e.g., number of indigent admissions, number of charity admissions, and inpatient days of care;

   c. demographic/patient origin data;

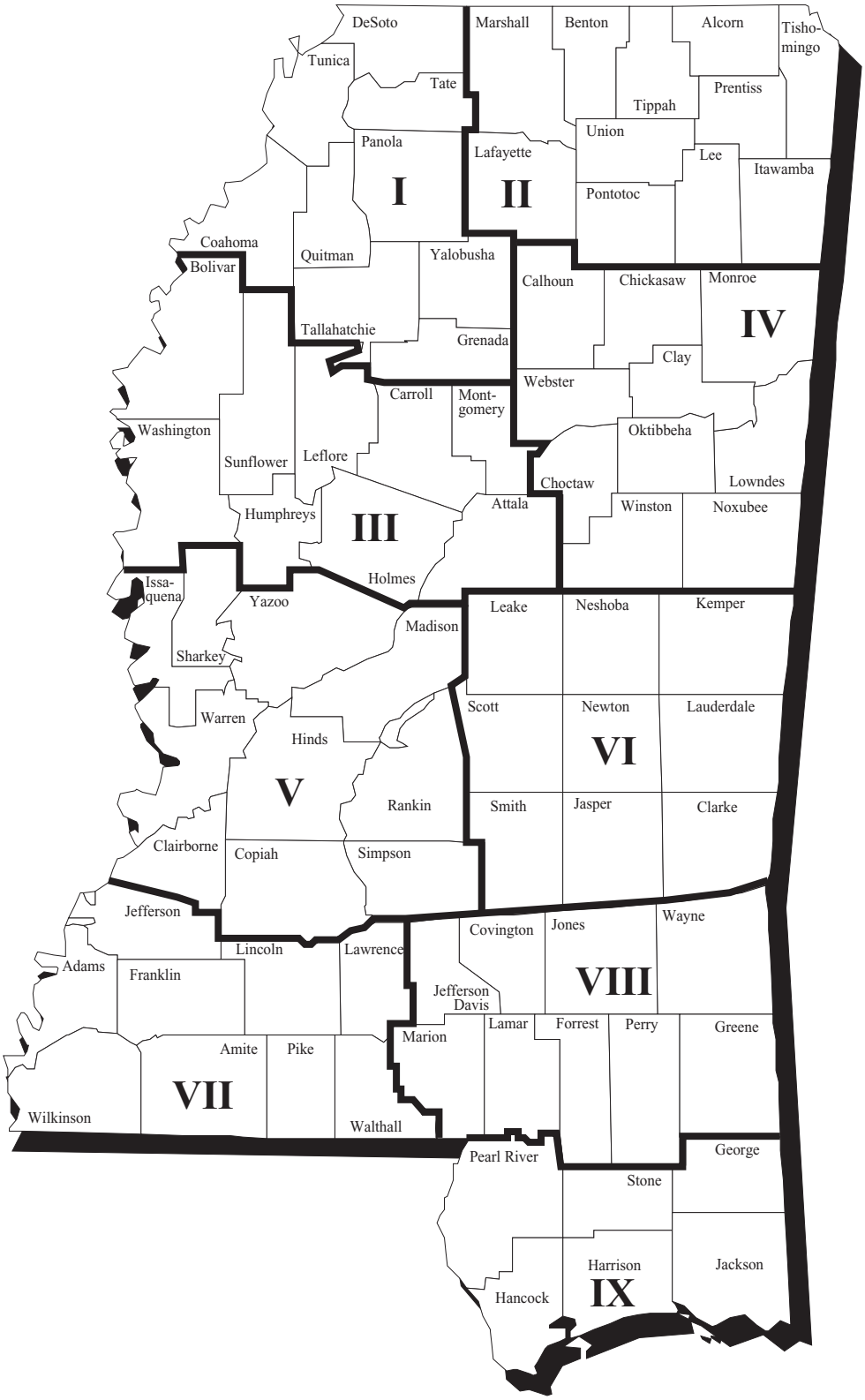
   d. cost/charges data; and

   e. any other data pertaining directly or indirectly to the utilization of services by medically indigent or charity patients which the Department may request.

6. The applicant shall document that within the scope of its available services, neither the facility nor its participating staff shall have policies or procedures which would exclude patients because of race, age, sex, ethnicity, or ability to pay.

Map X-3

Perinatal Planning Areas



Neonatal Special Care Services
Bed Need Methodology

The determination of need for neonatal special care beds/services in each Perinatal Planning Area will be based on four (4) beds per 1,000 live births as defined below. Table X-5 gives the neonatal special care bed need using 1999 data (most recent available).

1. One (1) neonatal intensive care bed per 1,000 live births in the most recent 12-month reporting period.

2. Three (3) neonatal intermediate care beds per 1,000 live births in the most recent 12-month reporting period.

Table X-5
Neonatal Special Care Bed Need
FY 2003

PPA	Number Live Births	Neonatal Intensive Care Bed Need	Neonatal Intermediate Care Bed Need
Region I	3,295	3	10
Region II	4,730	5	14
Region III	3,181	3	10
Region IV	3,178	3	10
Region V	11,119	11	33
Region VI	2,548	3	8
Region VII	2,493	2	7
Region VIII	4,952	5	15
Region IX	5,949	6	18

Source: Division of Vital Statistics, Mississippi State Department of Health